

907 KAR 17:015. Managed care organization requirements and policies relating to providers.

RELATES TO: KRS 194A.025(3), 205.593, 304.14-135, 304.17A-700-304.17A-730, 42 C.F.R. 431.52, Part 438, 447.45, 447.46, 42 U.S.C. 1396a(a)(37), 1396n, 1396u-2(b)(2)(A)(i)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 C.F.R. Part 438, 42 U.S.C. 1396n(b)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the managed care organization requirements and policies relating to providers.

Section 1. Provider Network. (1) An MCO shall:

(a) Enroll providers of sufficient types, numbers, and specialties in its network to satisfy the access and capacity requirements established in Section 2 of this administrative regulation; and

(b) Exclude, terminate, or suspend from the MCO's network a provider or subcontractor who engages in an activity that results in suspension, termination, or exclusion from a Medicare or Medicaid program.

(2) If an MCO or the department determines that the MCO's provider network is inadequate to comply with the access standards established in Section 2 of this administrative regulation for ninety-five (95) percent of the MCO's enrollees, the MCO shall:

(a) Notify the department; and

(b) Submit a corrective action plan to the department.

Section 2. Provider Access Requirements. (1) The access standards requirements established in 42 C.F.R. Part 438 shall apply to an MCO.

(2) An MCO shall make available and accessible to an enrollee:

(a) Facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section;

(b) Specialists available for the subpopulations designated in 907 KAR 17:010, Section 12; and

(c) Sufficient pediatric specialists to meet the needs of enrollees who are less than twenty-one (21) years of age.

(3) Emergency medical and behavioral health services shall be available and accessible twenty-four (24) hours a day, seven (7) days a week.

(4) Urgent care medical and behavioral health services shall be available and accessible within forty-eight (48) hours of request.

(5) Time and Distance Standards. (a) An MCO's primary care provider delivery site shall be within:

1. Thirty (30) miles or thirty (30) minutes from an enrollee's residence in an urban area; or

2. Forty-five (45) miles or forty-five (45) minutes from an enrollee's residence in a non-urban area.

(b) A hospital shall be within:

1. Thirty (30) miles or thirty (30) minutes from an enrollee's residence in an urban area; or

2. Sixty (60) miles or sixty (60) minutes of an enrollee's residence in a non-urban area.

(c) A behavioral or physical rehabilitation service, a dental service, a general vision service, a laboratory service, a radiological service, or a pharmacy service shall be within sixty (60) miles or sixty (60) minutes of an enrollee's residence.

(d)1. A pharmacy delivery site, except for a mail order pharmacy, shall not be further than fifty (50) miles from an enrollee's residence.

2. Transport time or distance threshold shall not apply to a mail-order pharmacy except that the mail-order pharmacy shall:

a. Be physically located within the United States of America; and

b. Provide delivery to the enrollee's residence.

(6) An MCO's primary care provider shall not have an enrollee to primary care provider ratio greater than 1,500:1.

(7) Appointment Wait Times. (a) Except as provided by subsection (3) or (4) of this section or paragraph (b) of this subsection, an appointment wait time for a primary care provider, behavioral health provider, specialist, or dental, general vision, laboratory, or radiological service shall not exceed thirty (30) calendar days from the date of an enrollee's request for a routine or preventive service.

(b) A behavioral health service appointment following a discharge from an acute psychiatric hospital shall occur within seven (7) calendar days of discharge.

Section 3. MCO Provider Enrollment. (1) A provider enrolled with an MCO shall:

(a) Be credentialed by the MCO in accordance with 42 C.F.R. Part 438; and

(b) Be enrolled with the Kentucky Medicaid Program in accordance with 907 KAR 1:672.

(2) An MCO shall:

(a) Have and maintain documentation regarding a provider's qualifications; and

(b) Make the documentation referenced in paragraph (a) of this subsection available for review by the department.

(3) A provider shall not be required to participate in Kentucky Medicaid fee-for-service to enroll with an MCO.

Section 4. Prompt Payment of Claims. (1) In accordance with 42 U.S.C. 1396a(a)(37), an MCO shall have prepayment and postpayment claims review procedures that ensure the proper and efficient payment of claims and management of the program.

(2) An MCO shall:

(a) Comply with the prompt payment provisions established in:

1. 42 C.F.R. 447.45 and 447.46; and

2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700 to 304.17A-730; and

(b) Notify a requesting provider of a decision to:

1. Deny a claim; or

2. Authorize a service in an amount, duration, or scope that is less than requested.

(3) The payment provisions in this section shall apply to a payment to:

(a) A provider within the MCO network; and

(b) An out-of-network provider.

Section 5. Primary Care Provider Responsibilities. (1) A PCP shall:

(a) Maintain:

1. Continuity of an enrollee's health care;

2. A current medical record for an enrollee; and

3. Formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of the PCP's

practice;

(b) Refer an enrollee for specialty care or other medically necessary services:

1. Within the MCO's network; or

2. If the services are not available within the MCO's network, outside the MCO's network;

(c) Discuss advance medical directives with an enrollee;

(d) Provide primary and preventive care, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;

(e) Refer an enrollee for a behavioral health service if clinically indicated; and

(f) Have an after-hours phone arrangement that ensures that a PCP or a designated medical practitioner returns the call within thirty (30) minutes.

(2) An MCO shall monitor a PCP to ensure compliance with the requirements established in this section.

Section 6. Release for Ethical Reasons. An MCO shall:

(1) Not require a provider to perform a treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. 438.102;

(2) Not prohibit or restrict a provider from advising an enrollee about health status, medical care, or a treatment:

(a) Whether or not coverage is provided by the MCO; and

(b) If the provider is acting within the lawful scope of practice; and

(3) Have a referral process in place if a provider declines to perform a service because of an ethical reason.

Section 7. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or

(2) Disapproves the policy. 907 KAR 17:015. (39 Ky.R. 1831; 2350; eff. 6-27-2013; 43 Ky.R. 1316; 1974; eff. 6-2-2017; -- Amd 44 Ky.R. 1441, 2075; eff. 5-4-2018.)